

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06972

Reg. Dist. No. 131

1. PLACE OF DEATH:
County... Frederick
City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, institution, or street address where death occurred:
154 West All Saint Street
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Frederick
City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No. 154 West All Saint Street
(If rural, give LOCATION)
2. (a) If veteran, name war..... None

3. (a) FULL NAME

ROSE MARIE AMBUSH

3. (b) Social Security Number

None

4. Sex F 5. Color or race C 6. (a) Single, married, widowed, or divorced S
6. (b) Name of husband or wife.....
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) May 5-1945
8. AGE: Years 0 Months 2 Days 14 If less than one day
..... hrs. min.

9. Birthplace Frederick-Frederick-Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

12. Name Charles E. Ambush
13. Birthplace Frederick County Maryland

14. Maiden name Maxine Fieland
15. Birthplace Frederick County Maryland

16. Informant Mrs. Charles E. Ambush
Address Frederick, Maryland

17. Burial St. Johns Cemetery Date thereof 7/20/45
(Burial, cremation, or removal, whichever) (month) (day) (year)
Cemetery or crematory Frederick, Maryland
Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son
Address Frederick, Maryland

19. 20 July 19 45 Elizabeth G. Heck
(Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 19 45 at 1:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 19 45 to July 19 19 45
and that I last saw him alive on July 18 19 45

Immediate cause of death Bronchopneumonia DURATION 5 hrs

Due to.....
Due to.....

Other conditions.....
(Includes pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury At Etchison Injured at work?

23. SIGNATURE M. R. Etchison M. D.
Frederick, Maryland M. D. or other
Address..... Date signed 7-19-45

RECEIVED
JUL 21 1945
BUREAU V. B.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482 +

CERTIFICATE OF DEATH



Reg. Dist. No. 06973 32

1. PLACE OF DEATH:

County Frederick
City or town Rural Burkittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Frederick
City or town Rural Burkittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war NA

3. (a) FULL NAME

Ruth A. Rusherman

3. (b) Social Security Number

NO

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Samuel Rusherman

7. Birth date of deceased (mo., day, yr.) June 28, 1883

8. AGE: Years 62 Months 0 Days 16 If less than one day

9. Birthplace Fairplay, Washington County, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joseph Emmert

13. Birthplace Fairplay, Md.

14. Maiden name Elizabeth Rowland

15. Birthplace Fairplay, Md.

16. Informant Samuel Rusherman

Address Burkittsville, Md.

Burial Date thereof 7-17-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant View Cemetery

Location Burkittsville, Md.

18. Funeral director Gladhill Co.

Address Middletown, Md.

19. July 17, 1945 Marie Gladhill
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1945 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to July 14, 1945

and that I last saw him alive on July 13, 1945

Immediate cause of death

Pulmonary edema

Myocardial infarction

Thrombotic embolism

Longs etc

Carcinoma Cerv

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. J. Price

Address Jefferson, Md. Date signed 7/7/45

M. D. or other

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JUL 23 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 134

1. PLACE OF DEATH:

County Frederick
 City or town Emmitsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Emmitsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Harry E. Bollinger

3. (b) Social Security Number

213-18-8156

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Alice Blair Bollinger7. Birth date of deceased (mo., day, yr.) September 17, 18746. (c) If alive, give age 66 years

8. AGE: Years Months Days If less than one day

70 10 10 hrs. min.9. Birthplace Adams County, Pennsylvania
(Town, county, and state)10. Usual occupation Butcher

11. Industry or business

12. Name Peter Bollinger13. Birthplace Adams County, Pennsylvania14. Maiden name Sarah Wolford15. Birthplace Adams County, Pennsylvania16. Informant Alice Blair BollingerAddress Emmitsburg, Maryland17. Burial Date thereof July 29, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain ViewLocation Emmitsburg, Maryland18. Funeral director H. L. AllisonAddress Emmitsburg, Maryland19. July 28, 45 M. F. Shuff
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 45 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 27, 1945 to July 27, 1945
and that I last saw him on July 27, 1945

Immediate cause of death

Cerebral Hemorrhage 1/2 hr.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

B. P. Shuff M. D. or other
July 28, 45 Date signed 7/27/45

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AUG 2 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

06975

CERTIFICATE OF DEATH



Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
114 W. Six St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 114 West 6th Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME Katie Boone

3. (b) Social Security Number
none

4. Sex F 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Leroy Boone

7. Birth date of deceased (mo., day, yr.) April 25, 1886 8. (c) If alive, give age 67 years

8. AGE: 49 Years 2 Months 18 Days If less than one day
hrs. min.

9. Birthplace Frederick, Maryland
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Laborer

FATHER 12. Name Laborer 13. Birthplace Frederick, Md.

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Leroy Boone
 Address 114 W. Six St. Frederick

17. Burial Burial Date thereof July 16, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Olivet

Location Frederick - Maryland

18. Funeral director H. M. Snyder
 Address Mt. Airy

19. 16 July 1945
 (Date rec'd by registrar) Registrar Elizabeth G. Heck

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945, at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1945 to July 13 1945, and that I last saw her alive on July 2 1945

Immediate cause of death Cerebral Embolism

Due to (Sudden Death)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Laurence Fahney, M.D.
 Address Frederick, Md. Date signed 7-14-45

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BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

06976

Reg. Dist. No. 136

1. PLACE OF DEATH:

County FrederickCity or town Frederick-Rural R. F. D. #2
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

Frederick Junction

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick-Rural R. F. D. #2
(If outside city or town limits, write RURAL and give nearest town)Street No. Frederick Junction

(If rural, give LOCATION)

2(a) If veteran, name war None

3. (a) FULL NAME

MAUDE LILLIAN CARPENTER

3. (b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>S</u>
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6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 19, 1903

6. (c) If alive, give age years

8. AGE:	Years	Months	Days	If less than one day
	<u>42</u>	<u>1</u>	<u>8</u> hrs. min.

9. Birthplace Frederick County Maryland
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Peter J. Carpenter13. Birthplace Frederick County Maryland14. Maiden name Harriett Virginia Hall15. Birthplace Frederick County Maryland16. Informant Mrs. William H. MainAddress 237 W. 5th St., Frederick, Md.17. Burial Date thereof 7/30/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount Olivet Cemetery
Location Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 28-July-1945 G. O. Anderson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27th, 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....
and that I last saw him/her DEAD July 27th, 1945

Immediate cause of death

Coronary thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. S. Thomas M. D. or otherAddress Frederick, Md. Date signed 7/27/45

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AUG 1 1945
BUREAU V.E.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 872

CERTIFICATE OF DEATH



Reg. Dist. No. 131

1. PLACE OF DEATH:

County FredricksCity or town Fredricks
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred Emergency HospitalHow long in hospital or institution? 2 1/2 hrs 2 mo.

3. (a) FULL NAME

Earl Lucian Cloutier

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 26, 1877

6. (c) If alive, give age..... years

8. AGE:

68

Years

None

Months

24

Days

If less than one day

hrs.min.

9. Birthplace

Montreal, Canada
(Town, county, and state)

10. Usual occupation

Physician

11. Industry or business

FATHER

12. Name

August Cloutier

13. Birthplace

Montreal, Canada

MOTHER

14. Maiden name

Marie Provencier

15. Birthplace

Quebec, Canada

16. Informant

Virginia Liddle

Address

Emergency Hosp. - Frederick Md.

17.

(Burial, cremation, or removal, which)

Date thereof

July 23-45
(month) (day) (year)

Cemetery or crematorium

St. Carmel's

Location

Thurmonk Md.

18. Funeral director

Thurmonk Md.

Address

Thurmonk Md.

19.

21-July19 45

Registrar

Elizabeth G. Hall

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Fredricks

City or town

Shillaville

Street No.

State Sanatorium

(If rural, give LOCATION)

2. (a) If veteran, name war

no

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 20, 45

at

9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 43 to July 20, 45and that I last saw him/her alive on July 20, 45

Immediate cause of death

multiple sclerosis

DURATION

5 years

Due to

Due to

Other conditions

Tropical Sores
Exhaustion6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. Laurence Gahney MD

M.D. or other

Address

Fredricks Md.Date signed 7-20-45

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JUL 23 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

06978

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Braddock Heights
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 weeks
 Hospital, institution, or street address where death occurred:
Jefferson Blvd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

District Columbia
 City or town Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1757 Lamont St. N.W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Lilly Rausberg Coblenz

3. (b) Social Security Number

none

4. Sex

female

5. Color or race

white

6. (a) Single married, widowed or divorced

widowed

6. (b) Name of husband or wife

Horace Coblenz
(dead)

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 5, 1875

8. AGE:

Years

Months

Days

If less than one day

7034

hrs.

min.

9. Birthplace

Middle town, Frederick, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Cemetery or crematory

Location

16. Funeral director

Address

19. (Date rec'd by registrar)

19.45-

Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Deputy Med. Ex.

M. D. or other

Address

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 9, 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw Mr. dead alive on July 9, 1945

Immediate cause of death

Coronary occlusion

DURATION

Undeclared

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. W. Baer

Deputy Med. Ex.

M. D. or other

Address

Frederick, Md.Date signed 7-10-45

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RECEIVED

RECEIVED
JUL 12 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, with UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

06979

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Buckeystown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Buckeystown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war None

3. (a) FULL NAME

HARRY COCKRELL

3. (b) Social Security Number

215-18-2722

4. Sex <u>M</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>M</u>
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6.(b) Name of husband or wife Margaret Stockman6.(c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) May 24, 1869

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>2</u>	<u>1</u>	hrs. min.

9. Birthplace Church Hill-Frederick-Maryland
(Town, county, and state)10. Usual occupation Retired Contractor

11. Industry or business

12. Name James Cockrell13. Birthplace Loudoun County Virginia14. Maiden name Amanda Richardson15. Birthplace Loudoun County Virginia16. Informant Mrs. Margaret S. CockrellAddress Buckeystown, Maryland17. Burial Date thereof 7/28/45

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Mount Olivet CemeteryLocation Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 26 July 1945 Elizabeth G. Heck

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25th, 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 17 to 19 25and that I last saw h. 17 alive on July 25, 1945Immediate cause of death Coronary occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE P. W. Baer Deputy ExAddress 100 E. 1st St. Frederick, Md. Date signed 7-26-45

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JUL 27 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1000)

CERTIFICATE OF DEATH

06980

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Frederick City HospitalHow long in hospital or institution? 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Thurmont
(If outside city or town limits, write RURAL and give nearest town)Street No. East Main St.,

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME

Roy Creeger.

3. (b) Social Security Number

213-01-6296

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Margaret A. CreegerB. (c) If alive, give age 51 years7. Birth date of deceased (mo., day, yr.) February 10, 18958. AGE: Years 50 Months 4 Days 25 It less than one day
.....hrs.min.9. Birthplace Thurmont, Frederick Co., Md.
(Town, county, and state)10. Usual occupation Storekeeper11. Industry or business Grocery Store12. Name J. Wesley Creeger13. Birthplace Thurmont, Md.14. Maiden name Effie Williar15. Birthplace Thurmont, Md.16. Informant Mrs Roy CreegerAddress Thurmont, Md.17. Burial Date thereof July 7, 1945
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Blue Ridge CemeteryLocation Thurmont, Md.18. Funeral director M. L. Creeger & SonAddress Thurmont, Md.19. 6 July 1945
(Date rec'd by registrar)Eligbeth H. Heck
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945 at 5:40 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1945 to July 5 1945 and that I last saw him alive on July 5 1945Immediate cause of death Pulmonary Embolism DURATION, 30 min.Due to Thrombosis - basis of leg ?
Operation - ligature & excision 8 daysDue to Varicose veins YearsOther conditions Varicose veins

(Include pregnancy within 3 months of death)

Major findings of operations Large dilated veins of left leg & varicose veins Date of op. June 27-1945Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Albrethington M. D. or otherAddress Frederick - Md Date signed July 5-1945

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JUL 10 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH



Reg. Diat. No.

1698139

1. PLACE OF DEATH:

County Frederick
 City or town Rural - Smithsburg RR#
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Rural - Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)Street No. W. Garfield (X. RR#)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edgar Eugene Cross

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Emma R. (Lewis) Cross6. (c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) April 9, 18888. AGE: Years 57 Months 3 Days 7 If less than one day

hrs. min.

9. Birthplace W. Hagerstown Wash. Co. Md

(Town, county, and state)

10. Usual occupation Farmer11. Industry or business Own Farm12. Name John G. Cross13. Birthplace Md.14. Maiden name Elizabeth Monte15. Birthplace Md16. Informant Mrs Emma R. CrossAddress Smithsburg P.R.#117. Burial (Burial, cremation, or removal Which?) BurialDate thereof July 18, 1945

(month) (day) (year)

Cemetery or crematory Bethel M.E.Location N. Garfield, Md18. Funeral director Thos. Bittel & SonAddress Myersville, Md19. Date rec'd by registrar July 18, 1945Registrar Warkoff

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14 1945, to July 16 1945and that I last saw him alive on July 14 1945Immediate cause of death Coronary ThrombosisDURATION 5 min.Due to Coronary SclerosisDue to 7 yrsOther conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations ✓Autopsy results ✓Date of op. ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (Where?) ✓Means of injury ✓ Injured at work? ✓23. SIGNATURE G. G. H. MillerM. D. or Ph.D. ✓Address Smithsburg Date signed 7/16/45

RECEIVED
JUN 20 1945
BUREAU OF
POSTAL INSPECTION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06982



Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
21 East Third Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 21 East Third Street
 (If rural, give LOCATION)
 2.(a) If veteran, name War World War I

3. (a) FULL NAME

ARTHUR HEDGES CULLER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced
Married

6. (b) Name of husband or wife Vera Marino Culler

7. Birth date of deceased (mo., day, yr.) December 1, 1900 6. (c) If alive, give age 44 years

8. AGE: Years 44 Months 7 Days 16 If less than one day
 hrs. min.

9. Birthplace Feagaville, Frederick Co., Maryland
(Town, county, and state)10. Usual occupation Superintendent-Disposal Plant

11. Industry or business

12. Name George B. Culler13. Birthplace Feagaville, Maryland14. Maiden name Tempie L. Hargett15. Birthplace Frederick County, Maryland16. Informant Mrs. Arthur H. CullerAddress Frederick, Maryland

17. Burial Date thereof July 19, 1945
 (Burial, cremation, or removal, White?) (month) (day) (year)

Cemetery or crematory CemeteryLocation Feagaville, Maryland18. Funeral director C. E. Cline & SonAddress Frederick, Maryland

19. 19 July 1945 Elizabeth L. Heck
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945 at 1 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1941 to July 17 1945and that I last saw him alive on July 17 1945Immediate cause of death DURATION

Chronic Valvular Heart Disease
+ 2 decompensation 4 years

Due to Chronic Valvular Heart Disease
1 week

Other conditions Acute Spontaneous
1 week

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE H. Lawrence Johnson MD

Frederick Md M. D. or other 7/19/45
 Address Date signed

RECEIVED

JUL 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. ¹ correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FredrickCity or town Frederick Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FredrickCity or town Walkersville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Annice Matilda Sinterman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband George Baltzel Sinterman7. Birth date of deceased (mo., day, yr.) Dec. 26, 1859 6. (c) In alive, give age _____ years8. AGE: Years 85 Months 7 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Fredrick County Maryland
(Town, county, and state)10. Usual occupation Amesbury11. Industry or business Abraham Washington Steel12. Name Mary Beard13. Birthplace Fredrick County Maryland14. Maiden name Frederick County Maryland15. Birthplace Frederick County Maryland16. Informant Elizabeth HeckAddress Emergency Hospital17. Burial, cremation, or removal (Which?) Burial Date thereof July 31, 1945
(month) (day) (year)Cemetery or crematory Cemetery - Mt HopeLocation Woodsboro18. Funeral director G. C. BartonAddress Walkersville19. 30 July 1945 Elizabeth Heck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945 at 6:30 P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 19, 1945 to July 27, 1945and that I last saw him/her on July 27, 1945Immediate cause of death Coronary Thrombosis

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Samuel P. EasterdayAddress Walkersville, Md M. D. or other _____Date signed July 30, 1945

RECEIVED
JUL 31 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

06984

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 YearsHospital, institution, or street address where death occurred:
22 South Court Street

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 22 South Court Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MAGGIE LUCINDA DORSEY

3. (b) Social Security Number

None

4. Sex <u>F</u>	5. Color or race <u>C</u>	6. (a) <u>Single</u> married, widowed, or divorced <u>W</u>
--------------------	------------------------------	--

6. (b) Name of husband or wife John A. Dorsey7. Birth date of deceased (mo., day, yr.) March 27, 1878
6. (c) If alive, give age..... years

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>3</u>	<u>26</u> hrs. min.

9. Birthplace Frederick County Maryland
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business

12. Name Alfred Dillard13. Birthplace Frederick County Maryland14. Maiden name Mary E. Murdock15. Birthplace Frederick County Maryland16. Informant Mrs. Leroy WilsonAddress Frederick, Maryland17. Burial Date thereof 7/25/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or Fairview CemeteryLocation Frederick, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 24 July 1945 Elizabeth G. Heck-
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23rd, 1945 at 2:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16th 1945 to July 23rd 1945 and that I last saw him alive on July 23rd 1945Immediate cause of death Cerebral Apoplexy DURATION 4 daysDue to Arteriosclerosis years

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Ulysses S. Bourne M. D.Address Frederick, Maryland Date signed 7-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUL 25 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of sex is shown on

FILM No G 96 JUL 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

Reg. Dist. No. 06985/45

1. PLACE OF DEATH:

County Frederick

City or town Myersville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Frederick

City or town Myersville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

ETTA E. M. FLOOK

3. (b) Social Security Number

no

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1868

8. AGE: Years 76 Months 10 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Myersville, Frederick Co. Md.
(Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business

12. Name John Flook

13. Birthplace Myersville, Md.

14. Maiden name Rebecca Darr

15. Birthplace Middletown, Md.

16. Informant Oscar L. Flook

Address Myersville, Md.

17. Burial Date thereof 7-12-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Middletown, Md.

18. Funeral director Gladhill Co.

Address Middletown, Md.

19. July 12, 45 Edgar Bitts
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1945 at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 19 45 to July 10 19 45

and that I last saw her alive on July 7 19 45

Immediate cause of death _____

Cerebral Hemorrhage DURATION 3 mo.

Due to _____

Due to Arteriosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J E Harp MD

M. D. or other _____

Address Middletown Date signed 7-11-45

RECEIVED
JUL 14 1965
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

★ Reg. Dist. No. 131

1. PLACE OF DEATH:

County **Frederick**City or town **Frederick-Rural R. F. D. #5**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **15 years**

Hospital, institution, or street address where death occurred:

Braddock

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Frederick**City or town **Frederick-Rural R. F. D. #5**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **Braddock**

(If rural, give LOCATION)

2.(a) If veteran, name war..... **None**

3. (a) FULL NAME

WALTER S. GRAHAM

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6. (b) Name of husband or wife **Catherine Doll**6. (c) If alive, give age **70** years7. Birth date of deceased (mo., day, yr.) **October 5, 1871**

8. AGE: Years Months Days If less than one day

73**9****22**

hrs. min.

9. Birthplace **Indiana**

(Town, county, and state)

10. Usual occupation **Operated Tourist Home**11. Industry or business **His Own**12. Name **Unknown**13. Birthplace **Unknown**14. Maiden name **Unknown**15. Birthplace **Unknown**16. Informant **Mrs. Catherine D. Graham**Address **R. F. D. #5, Frederick, Md**17. Burial **7/30/45**

(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory **Frederick Memorial Park**Location **Frederick, Maryland**18. Funeral director **M. R. Etchison and Son**Address **Frederick, Maryland**19. **30 July 1945** **Elizabeth G. Heck**

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 27th, 1945** at **8 A** M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April 1944** to **July 27 1945**and that I last saw him alive on **July 26 1945**

Immediate cause of death

DURATION

Coronary OcclusionDue to **(Sudden)**

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results **not done** Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **J. E. Harp** **M. D.**Address **Middletown, Maryland** M. D. or otherDate signed **7-28-45**

RECEIVED
JUL 31 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County FredrichCity or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FredrichCity or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Frederick Green

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife _____

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 19-1874

8. AGE: Years Months Days If less than one day

71119hrs.min.9. Birthplace Carroll Co Maryland
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name Fredrich Green13. Birthplace Maryland14. Maiden name Cordelia D. Wise15. Birthplace Maryland16. Informant Mrs. John E. BrownAddress Union Bridge Md17. Burial Date thereof July 12-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain View CemLocation Union Bridge Md18. Funeral director D. D. Weather & SonAddress Union Bridge & New Windsor Md19. July 12 19 45

(Date registered by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 45, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him/her live on July 9 19 45Immediate cause of death Coronary occlusion

DURATION

Due to Coronary sclerosis acute

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE P. W. Barr Deputy Med. Ex.

M. D. or other

Address Fredrich, Md Date signed 7.9.45

RECEIVED
AUG 3 1945
BUREAU V.S.

Evidence for change of
age & birth date of deceased
is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06988

FILED AUG 9 7 AUG 17 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County... **Frederick**
City or town... **State Sanatorium, Maryland**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **Since 12/30/40**
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? **Since 12/30/40**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... **Maryland** County... **Prince George**
City or town... **Anacostia**
(If outside city or town limits, write RURAL and give nearest town)
Street No... **Route #2**
(If rural, give LOCATION)
2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Sophia Hamilton

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 12, 1876-1866

8. AGE:

Years

79

Months

69

Days

2

If less than one day

20

hrs. min.

9. Birthplace

Flesherton, Ontario, Canada

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Peter Campbell

13. Birthplace

Glasgow, Scotland

14. Maiden name

Sophia McCann

15. Birthplace

Nassagway, Ontario, Canada

16. Informant

Deceased

Address

17.

Burial
(Burial, cremation, or removal, which?)

Date thereof

July 5, 1945
(month) (day) (year)

Cemetery or crematory

Soldier's Home

Location

Washington, D.C.

18. Funeral director

Address

517-11th St NW Wash DC

19.

7/2/45
(Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH... **July 2** 19 **45** at **7:50 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 30 19 **40** to **July 2** 19 **45**

and that I last saw him/her alive on **July 2** 19 **45**

Immediate cause of death

Pulmonary Tuberculosis

DURATION

6 1/2 Yrs.

Due to

Due to

Other conditions

Diabetes Mellitus

(include pregnancy within 8 months of death)

10 Yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. Lynn

M. D. **XXXX**

Address... **State Sanatorium, Md.** Date signed **7/2/45**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH



Reg. Dist. No. 139

06989

1. PLACE OF DEATH:

County **Frederick**
 City or town **State Sanatorium, Maryland**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **Since 7/5/45**
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? **Since 7/5/45**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State **Maryland** County
 City or town **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **1213 N. Ensor St.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

Edward D. Hanlon

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 1, 1898

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

47**2****18**

hrs.

mo.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

FATHER

12. Name

Dennis Hanlon

13. Birthplace

Scotland

MOTHER

14. Maiden name

Elizabeth Waldron

15. Birthplace

Ireland

16. Informant

Deceased

Address

17.

BurialDate thereof **7/23/45**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery

~~XXXXXX~~ New Cathedral

Location

Baltimore, Md.

18. Funeral director

M.L. Creager & Son

Address

Thurmont, Md.

19.

7/20/45
(Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 19 1945 11:45P**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 5 1945 to July 19 1945
 and that I last saw him alive on **July 19 1945**

Immediate cause of death

Pulmonary Tuberculosis

DURATION

9 Mos.

Due to

Due to

Other conditions

Diabetes Mellitus

(Include pregnancy within 3 months of death)

4 Yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. **XXXX**Address **State Sanatorium, Md.** Date signed **7/20/45**

RECEIVED
JUL 21 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 06999 / 140

1. PLACE OF DEATH:

County FrederickCity or town Le Gore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Le Gore
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Amos Fern Hoff4. Sex M. Color or race W. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Dora Fern Speck6.(c) If alive, give age 44 years7. Birth date of deceased (mo., day, yr.) Feb. 8, 18958. AGE: Years 50 Months 4 Days 26 If less than one day _____ hrs. _____ min.9. Birthplace Carroll Co. Md.
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business _____

12. Name Geo. A. Hoff13. Birthplace Ill.14. Maiden name Anna Belle Mentzer15. Birthplace Md.16. Informant Mrs. Amos F. HoffAddress Le Gore, Md.17. Burial Date thereof July 7, 1945
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Mt. HopeLocation Woodsboro, Md.18. Funeral director Russell & HartleyAddress Woodsboro, Md.19. July 5, 1945 L. B. Souree
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

216-07-2032

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945 at 6:09 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1945 to July 4, 1945and that I last saw him alive on July 4, 1945Immediate cause of death Myocardial infarction DURATION 5 yearsDue to Cor. Ar.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. Mason M.D. M. D. or other _____Address Belleville Date signed July 4

RECEIVED
JUL 7 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06991



Reg. Dist. No. 131

1. PLACE OF DEATH:
 County Frederick
 City or town Near Jefferson R.D., Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Near Jefferson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Frederick, d. R. D. 4
 (If rural, give LOCATION)
 2(a) If veteran, name war none

3. (a) FULL NAME
John William Hoffman

3. (b) Social Security Number
none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced—
 6. (b) Name of husband or wife Annie C. Schaeffer
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) Nov. 30, 1874
 8. AGE: Years 70 Months 7 Days 25 It less than one day
hrs.min.

9. Birthplace Near Feagaville, Frederick, Md.
 (Town, county, and state)
 10. Usual occupation retired farmer

11. Industry or business

FATHER 12. Name William N. Hoffman
 13. Birthplace Near Jefferson, Md.
 MOTHER 14. Maiden name Margaret Biser,
 15. Birthplace Jefferson, Md.

16. Informant George W. Hoffman,
Frederick, Md. R. D. 4
 Address

17. burial Date thereof 7/28 / 45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mount Olivet cemetery
Frederick, Md.
 Location

18. Funeral director M. R. Etchison & Son,
 Address Frederick, Md.

19. 26 July 19 45 Elizabeth G. Heck
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25th., 19 45 5.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 19 45 to July 25 45
 and that I last saw him alive on July 23 45

Immediate cause of death Pulmonary Edema
 DURATION 5 Days

Due to Myocarditis + 3 yrs
Inflammation

Due to Cerebral Hemorrhage 3 yrs

Other conditions Spinal Cord Artery - 5 yrs
5 claud
 (Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of Injury..... Injured at work?

23. SIGNATURE C. L. Lusk M. D. or other
Jefferson, Md. Date signed 7/25/45

RECEIVED
JUL 27 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

06992

CERTIFICATE OF DEATH

Reg. Diat. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 days
 Hospital, institution, or street address where death occurred:
Frederick City Hospital

How long in hospital or institution? 47 days

3. (a) FULL NAME

Bessie Edline Horine

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife J. Phillip Horine

7. Birth date of deceased (mo., day, yr.) Oct 16 - 1888 6. (c) If alive, give age 56 years

8. AGE: Years 56 Months 9 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Stroudsburg Pa.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Douglas

13. Birthplace Pa.

14. Maiden name Clara Mowers

15. Birthplace Pa.

16. Informant J. Phillip Horine

Address Boyd, R. 2, W.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof July 31-45
 (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville Ind.

18. Funeral director William B. Hilton

Address Barnesville Ind.

19. 29 July 1945 Registrar Elizabeth G. Heck
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Boyd - Rural
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945 at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1945 to July 28 1945

and that I last saw him alive on July 28 1945

Immediate cause of death _____ DURATION _____

Coronary occlusion

Due to _____

Due to _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Cholelithiasis

Antopsy results _____ Date of op. July 24

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. P. Thomas M. D. or other _____

Address Frederick, Md. Date signed July 28

RECEIVED
JUL 31 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06993

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 9/6/34
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 9/6/34

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Henry E. Isabella

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 B. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 11, 1883
 8. AGE: Years 61 Months 10 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Germany
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business _____
 FATHER 12. Name Emil Isabella
 13. Birthplace Germany
 MOTHER 14. Maiden name Louise Myer
 15. Birthplace Germany
 16. Informant Deceased

Address _____
 17. Reburied Date thereof July - 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Blue Ridge
 Location Thurmont, Md.
 18. Funeral director M. L. Creager & Son
 Address Thurmont, Md.
 19. 7/21/45 19 _____
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 45 at 11:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6 19 34 to July 2 19 45
 and that I last saw him alive on July 2 19 45

Immediate cause of death Pulmonary Tuberculosis DURATION 11 Yrs.

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE J. B. Lyon M. D. 1306X
 Address State Sanatorium, Md. Date signed 7/3/45

RECEIVED

JUL 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

CERTIFICATE OF DEATH

06994

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick-Rural R. F. D. #3
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Years

Hospital, institution, or street address where death occurred:

Bloomfield

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick-Rural R. F. D. #3
(If outside city or town limits, write RURAL and give nearest town)Street No. Bloomfield

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (a) FULL NAME

JOHN CALVIN JACOBS

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6. (b) Name of husband or wife Rosa Winpigler6. (c) If alive, give age 59 years7. Birth date of deceased (mo., day, yr.) September 15, 1871

8. AGE:

Years

Months

Days

If less than one day

73925

hrs.

min.

9. Birthplace Frederick County Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Andrew Jacobs13. Birthplace Frederick County Maryland

MOTHER

14. Maiden name Laura Winpigler15. Birthplace Frederick County Maryland16. Informant Mrs. Rosa W. JacobsAddress Frederick, Md. R. F. D. #3

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7/13/45

(month) (day) (year)

Cemetery or crematory Mount Hope CemeteryLocation Woodsboro, Maryland18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland19. 11-July 19 45

(Date rec'd by registrar)

Elizabeth G. Heck
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10th, 19 45 at 8:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 8 19 45, to July 10 19 45and that I last saw him alive on July 9 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Legg
Union Bridge

M. D.

M. D. or other

Address Union Bridge Date signed 7-11-45

RECEIVED
JUL 12 1968
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06995

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1613 Hakesley Place
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James E. Johnson

3. (b) Social Security Number

218-03-5278

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.) Jan. 3, 1902

8. AGE:

Years

43

Months

6

Days

12

If less than one day

hrs. min.

9. Birthplace

Wheatland, W. Va.

(Town, county, and state)

10. Usual occupation

Pipe fitter

11. Industry or business

FATHER

12. Name Granville Johnson

MOTHER

13. Birthplace

14. Maiden name Anna ?

15. Birthplace

16. Informant

Address

17.

Burial Method Date thereof July 19, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Mt. Carmel Cemetery

Location

Thurmont, Frederick Co. Md.

18. Funeral director

M.L. Creager & Son

Address

Thurmont, Md.

19.

(Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945 at 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 14 1944 to July 15 1945and that I last saw him alive on July 15 1945

Immediate cause of death

Pulmonary Tuberculosis

DURATION

10 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address State Sanatorium, Md. Date signed 7/16/45

RECEIVED
JUL 18 1965
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-4

CERTIFICATE OF DEATH

06996

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 5/12/45
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 5/12/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Seat Pleasant
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7019 F St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Thelma May Johnson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband ~~xxx~~ Claude Johnson 6.(c) If alive, give age 33 years
 7. Birth date of deceased (mo., day, yr.) April 4, 1918
 8. AGE: Years 27 Months 3 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Montgomery County, Md.
 (Town, county, and state)
 10. Usual occupation Housewife

11. Industry or business

12. Name Lawerance Turner
 13. Birthplace Maryland
 14. Maiden name Abbie Sartain
 15. Birthplace West Virginia
Deceased

16. Informant _____
 Address _____

17. Buried Date thereof July 12, 1945
 (Burial, cremation, or other) (month) (day) (year)

Cemetery or crematory Elizabeth Washington Memorial
 Location Riggs Mills Rd., Washington, D.C.
W.W. Chambers

18. Funeral director _____
 Address 507-11th St SE
7/9/45

19. _____ 19. _____
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945 at 2:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1945 to July 9 1945
 and that I last saw her alive on July 9 1945

Immediate cause of death Pulmonary Tuberculosis DURATION 11 Mos.

Due to Laryngeal Tuberculosis 5 Mos.

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Mans of injury _____ Injured at work? _____

23. SIGNATURE J.B. Lynn M. D. 06996

Address State Sanatorium, Md. Date signed 7/9/45

RECEIVED
JUL 11 1965
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66997

Reg. Dist. No. 141

1. PLACE OF DEATH:

County FredrickCity or town Brownsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 daysHospital, institution, or street address where death occurred Schwartz HospitalHow long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Isapland
(If outside city or town limits, write RURAL and give nearest town)Street No. Isapland md
(If rural, give LOCATION)2. (c) If referan, name war none

3. (a) FULL NAME

Nellie Sophia Kaetzl

3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Fra E. Kaetzl7. Birth date of deceased (mo., day, yr.) October 15, 1888 6. (c) If alive, give age years8. AGE: Years 56 Months 8 Days 28 If less than one day hrs. min.9. Birthplace Brownsville Wash. Co. md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own Home12. Name Samuel Jennings13. Birthplace Brownsville md.14. Maiden name Anna Spielman15. Birthplace Sharpsburg md.16. Informant Fra E. KaetzlAddress Isapland md17. Burial Date thereof July 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Church of the Brothers CemeteryLocation Brownsville md.18. Funeral director Wm. F. Bast & SonsAddress Brownsville md19. July 14 - 1945 Anna Kaetzl
(Date registered by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 19 45, at 9 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 19 45 to July 13 19 45and that I last saw him alive on July 13 19 45Immediate cause of death Coronary Thromboses DURATION Plus

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Abd serial culturesDate of op. July 11, 45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Schaeffer M. D. or otherAddress Brownsville Date signed July 14, 45

RECEIVED
JUL 17 1968
BUREAU V.P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 135

1. PLACE OF DEATH:

County Frederick
 City or town Rural Myersville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Frederick
 City or town Rural Myersville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John E. King
 4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife A. Pearl King
 6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 26, 1895

8. AGE: Years 50 Months 0 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Myersville, Frederick Co. Md.
 (Town, county, and state)

10. Usual occupation Day Laborer

11. Industry or business _____

12. Name John King

13. Birthplace Myersville, Md.

14. Maiden name Carrie Lizer

15. Birthplace Myersville, Md.

16. Informant A. Pearl King

Address Myersville, Md.

17. Burial Date thereof 7-14-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Frederick Memorial Park Cemetery

Location Frederick, Md.

18. Funeral director Gladhill Co.

Address Middletown, Md.

19. July 14 1945 Charles L. Leatherman
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

219-12-0270

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1945 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1945 to July 11, 1945

and that I last saw him alive on July 11, 1945

Immediate cause of death Carcinoma of liver DURATION 10 mo.

Due to _____

Due to _____

Other conditions _____

RECEIVED
AUG 4 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:
County Frederick
Frederick-Rural R. F. D. #5
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, institution, or street address where death occurred:
Near Shookstown
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City Frederick-Rural R. F. D. #5
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Shookstown
(If rural, give LOCATION)
None
2.(a) If veteran, name war

3. (a) FULL NAME
LOLA ANN REBECCA KLINE

3. (b) Social Security Number
None

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>W</u>	
6. (b) Name of husband or wife <u>Charles D. Kline</u>		6. (c) If alive, give age..... years	
7. Birth date of deceased (mo., day, yr.) <u>February 27, 1866</u>			
8. AGE: Years <u>79</u>	Months <u>4</u>	Days <u>21</u>	If less than one dayhrs.min.

9. Birthplace Frederick County Maryland
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Peter Kline
13. Birthplace Frederick County Maryland

MOTHER
14. Maiden name Catherine Kline
15. Birthplace Frederick County Maryland

16. Informant Charles M. Kline
Address Frederick, Md. R. F. D. #5

17. Burial Rocky Springs Cemetery
(Burial, cremation, or removal, which?) Date thereof 7/21/45
(month) (day) (year)
Cemetery or crematory Near Frederick, Maryland
Location

18. Funeral director M. R. Etchison and Son
Address Frederick, Maryland

19. 19 July 19 45 Elizabeth G. Heck
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1944 to July 18, 1945
and that I last saw him alive on July 18, 1945

Immediate cause of death.....
Chronic Myocarditis 2 foci
DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. D. Thomas M. D.

Frederick, Maryland M. D. or other 7-19-45

Address..... Date signed.....

RECEIVED

JUL 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 456 +

CERTIFICATE OF DEATH

07000

★ Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 2/23/44
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 2/23/44

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 139 N. Kenwood Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Barney Krocheski

3.(b) Social Security Number

217-01-3575

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 25, 1899
 8. AGE: Years 45 Months 9 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Detroit, Mich.
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business _____
 12. Name John Krocheski
 13. Birthplace Russia
 14. Maiden name Rose ?
 15. Birthplace Poland
 16. Informant Deceased

Address Bureau
 17. (Burial, cremation, or removal. Which?) Interment
 Date thereof July 31, 1945
 Cemetery or crematory St. Ignace Cemetery
 Location Baltimore Co., Md.
 18. Funeral director Flakowski
 Address 1618 Union Ave. Baltimore
 Date rec'd by registrar 7/27/45 Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 45, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23 19 44 to July 27 19 45
 and that I last saw him alive on July 27 19 45

Immediate cause of death Carcinoma of Tongue DURATION 10 Mos.

Due to _____

Due to _____

Other conditions Pulmonary Tuberculosis 21 Mos.
 (Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Tongue Date of op. Oct. 27, 1944

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE J. B. Lynn M. D. State Sanatorium, Md.
 Date signed 7/28/45

RECEIVED
JUL 30 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07001

★ Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
313 West Patrick Street
 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 313 West Patrick Street
 (If rural, give LOCATION)
 2(a) If veteran, name war None

3. (a) FULL NAME

MAE E. LAMBERT

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 B. (b) Name of husband or wife None
 B. (c) If alive, give age ----- years
 7. Birth date of deceased (mo., day, yr.) February 4, 1891
 8. AGE: Years 54 Months 5 Days 14 if less than one day ----- hrs. ----- min.

9. Birthplace Frederick, Maryland
 (Town, county, and state)

10. Usual occupation None

11. Industry or business -----

FATHER 12. Name Murray Lambert

13. Birthplace Frederick County, Maryland

MOTHER 14. Maiden name Mary Elizabeth Mussetter

15. Birthplace Frederick County, Maryland

16. Informant Russell Lambert

Address Frederick, Maryland

17. Burial Date thereof July 21, 1945
 (Burial, cremation, or removal, which) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Frederick, Maryland

18. Funeral director C. E. Cline & Son

Address Frederick, Maryland

19. 20 July 19 45 Elizabeth B. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 45 at 7:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 44 to July 18 19 45

and that I last saw him alive on July 18 19 45

Immediate cause of death Carcinoma of Stomach DURATION -----

Due to -----

Due to -----

Other conditions Ch. Myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE H Lawrence Fakhry MD M. D. or other

Address Frederick MD Date signed 7-20-45

CERTIFICATE OF DEATH

RECEIVED
JUL 21 1945
BUREAU V. S.

Dr. H. H. H. H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1342)

CERTIFICATE OF DEATH



Reg. Dist. No. 0700240

1. PLACE OF DEATH:

County Frederick
 City or town Woodstock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Woodstock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Annie Mary Lemhart

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

F. W. Widow6. (b) Name of husband or wife Chas. C. Lemhart7. Birth date of deceased (mo., day, yr.) Mar. 12, 1876 6. (c) If alive, give age years8. AGE: Years Months Days If less than one day
69 3 29 hrs. min.9. Birthplace Frederick Co. Md.
(Town, county, and state)10. Usual occupation House wife11. Industry or business Own home12. Name G. Jacob Messell13. Birthplace Frederick Co. Md.14. Maiden name Catharine A. Spouseller15. Birthplace Frederick Co. Md.16. Informant Miss Mary S. LemhartAddress Woodstock, Md.17. Burial Date thereof July 14, 1945
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory UticaLocation near Lewisstown Md18. Funeral director Burke & HartzlerAddress Woodstock, Md.19. July 13, 1945 G. C. Messell
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1945 19 45 at 11:30 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 1943 19 43 to July 11, 1945 19 45 and that I last saw him alive on July 10, 1945 19 45Immediate cause of death Hypertensive Cardio Vascular
renal disease

DUE TO

DUE TO

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. C. Messell M. D. or otherAddress Walthamville Md Date signed July 13, 1945

RECEIVED
JUL 16 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07003



Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

119 East Fifth StreetHow long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 119 East Fifth Street
(If rural, give LOCATION)2(a) If veteran, name war None

3. (a) FULL NAME

JOHN ISAAC MAKEL

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Emma Makel5. (c) If alive, give age 60 years

7. Birth date of

deceased (mo., day, yr.)

December 25, 1877

8. AGE:

Years

Months

Days

If less than one day

67622

.....hrs.min.

9. Birthplace

Ijamsville, Maryland
(Town, county, and state)

10. Usual occupation

Janitor and Truckman

11. Industry or business

NoneFATHER
MOTHER

12. Name

Benjamin Makel

13. Birthplace

Washington, D. C.

14. Maiden name

Harriett Bowie

15. Birthplace

Frederick County, Maryland

16. Informant

Mrs. John Makel

Address

Frederick, Maryland

17.

Burial

(Burial, cremation, or removal, which?)

Date thereof July 20, 1945
(month) (day) (year)

Cemetery or crematory

Fairview Cemetery

Location

Frederick, Maryland

18. Funeral director

C. E. Cline & Son

Address

Frederick, Maryland

19.

17 July 1945
(Date read by registrar)Elizabeth G. Heck
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945, at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

....., 19....., to....., 19.....
and that I last saw him/her on July 17 1945

Immediate cause of death

coronary occlusion

DURATION

5 minutes

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

P. W. Bau

M. D. or other

Address.....

Date signed 7.17.45

RECEIVED
JUL 19 1945
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07004

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 5/23/45
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 5/23/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 505 W. Pratt St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John C. Martin

3. (b) Social Security Number

478-22-6033

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Separated

8. (b) Name of ~~XXXX~~ wife Edith Martin

7. Birth date of deceased (mo., day, yr.)

February 12, 1902

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

43

4

21

_____ hrs. _____ min.

9. Birthplace

Dunbar, Pa.

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

FATHER
MOTHER12. Name Bud Martin13. Birthplace Mt. Braddock, Pa.14. Maiden name Lula B. Martin15. Birthplace Dunbar, Pa.

16. Informant

Deceased

Address

17.

Removal
(Burial, cremation, or removal, which?)

Date thereof

July 19, 1945
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

M. L. Creager & Son

Address

Thurmont, Maryland

19.

7/4/45
(Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 45 at 10:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 23 19 45 to July 3 19 45and that I last saw him alive on July 3 19 45

Immediate cause of death

Pulmonary Tuberculosis

DURATION

13 Yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

J. B. LynnM. D. XXXXAddress State Sanatorium, Md. Date signed 7/4/45

RECEIVED
JUL 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 7/5/45
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 7/5/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 126 S. Calverton St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Reese Edward Miller

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 25, 1886

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

59

2

26

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

George Miller

13. Birthplace

New York

MOTHER

14. Maiden name

Louise ?

15. Birthplace

Maryland

16. Informant

Wm. H. Miller (Brother)

Address

Baltimore, Md.

17.

Burial

Date thereof

7/23/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery

~~Rock Hill~~

Western

Location

Baltimore, Md.

18. Funeral director

M. L. Creager & Son

Address

Thurmont, Md.

19.

(Date read by registrar)

19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 45 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 519 45to July 2119 45and that I last saw him alive on July 21 19 45

Immediate cause of death

Pulmonary Tuberculosis

DURATION

7 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. D. Lynn

M. D. ~~1945~~

Address

State Sanatorium, Md.

Date signed

7/21/45

RECEIVED
JUL 26 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 3/19/45
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 3/19/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

William Nash

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Separated
 6. (b) Name of ~~husband~~ wife Blanch Selden Nash
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) January 19, 1877
 8. AGE: Years 68 Months 5 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Leonardtown, Md.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business _____
 12. Name John S. Nash
 13. Birthplace Leonardtown, Md.
 14. Maiden name Moriah Dyer
 15. Birthplace Leonardtown, Md.

16. Informant Deceased
 Address Burial
 17. Burial Date thereof July 13, 1945
 (Burial, cremation, or other) (month) (day) (year)
 Cemetery or crematory St. Mary's Cemetery
 Location Leonardtown, St. Mary's Co. Md.
 18. Funeral director M. L. Creager & Son
 Address Thurmont, Maryland
 19. 7/11/45 19 _____
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 45 at 11:30 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 19 19 45 to July 10 19 45
 and that I last saw him alive on July 10 19 45

Immediate cause of death
Pulmonary Tuberculosis

DURATION
3 Yrs.

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE [Signature] M. D. [Signature]
 Address State Sanatorium, Md. Date signed 7/11/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 14 1945
BUREAU A. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Frederick City HospitalHow long in hospital or institution? 6/9/45

3. (a) FULL NAME

Elizabeth
Mrs. Maryetta Offutt

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or

Joe. Edw. Offutt

7. Birth date of deceased (mo., day, yr.)

May 17 - 1866

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

791616hrs.min.

9. Birthplace

Montgomery County
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

FATHER

12. Name

John L. Beatts

13. Birthplace

Maryland

MOTHER

14. Maiden name

Maryetta E. Offutt

15. Birthplace

Maryland

16. Informant

Rammond Beatts

Address

Rockville - Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 4 - 1945
(month) (day) (year)

Cemetery or crematory

Rockville Union Cem.

Location

Rockville - Maryland

18. Funeral director

Wm. Reuben Campbell

Address

Rockville - Md.19. July 2

1945

(Date rec'd by registrar)

Elizabeth G. Heck

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Montgomery

City or town

Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 219 45, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 9 19 45 to July 2 19 45and that I last saw him alive on July 2 19 45

Immediate cause of death

DURATION

Acute Coronary Thrombosis3 days

Due to

Arteriosclerosis?

Other conditions

Coronary Sclerosis6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Justin Pearce M.D.

M. D. or other

Address

712 E. Frederick St.Date signed 7/2/45

RECEIVED
JUL 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH: *Frederick*
 County.....
 City or town.....*Brownsville, Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....*17 days*
 Hospital, institution, or street address where death occurred:
Schnaufer Hospital
 How long in hospital or institution?.....*17 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Washington*
 City or town.....*Sandy Hook, Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Francis Estelle Powers

3. (b) Social Security Number

220-16-3731

4. Sex.....*Female* 5. Color or race.....*White* 6. (a) Single, married, widowed, or divorced.....*Married*
 6. (b) Name of husband or wife.....*William H. Powers*
 6. (c) If alive, give age.....*58* years

7. Birth date of deceased (mo., day, yr.).....*Nov 12 1902*
 8. AGE: Years.....*42* Months.....*8* Days.....*12* If less than one day..... hrs. min.

9. Birthplace.....*District of Columbia*
 (Town, county, and state)

10. Usual occupation.....*House Wife*

11. Industry or business.....*None*

12. Name.....*Not Known*

13. Birthplace.....*Not Known*

14. Maiden name.....*Not Known*

15. Birthplace.....*Not Known*

16. Informant.....*William H. Powers*

Address.....*Knoxville, Md. R.R. #1*

17. Burial Date thereof.....*July 27, 1945*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*National Cemetery*

Location.....*Sharpsburg, Md.*

18. Funeral director.....*J. H. Backus*

Address.....*Bolivar, W. Va.*

19. Date rec'd by registrar.....*July 24 1945*

Registrar.....*Emma Kantur*

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*July 24 1945* at.....*3:30* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*July 6 1945* to.....*July 24 1945*

and that I last saw him alive on.....*July 24 1945*

Immediate cause of death.....*Pulmonary Embolism*

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Due to.....

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Due to.....

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Other conditions.....

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RECEIVED
JUL 26 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 07009
 Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 4/11/45
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 4/11/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1902 W. Lexington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Carl Pransinkas

3. (b) Social Security Number

220-07-1178

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

8.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) May 1, 1904 6.(c) If alive, give age _____ years

8. AGE: Years 41 Months 2 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Handyman

11. Industry or business _____

12. Name Carl Pransinkas13. Birthplace Russia14. Maiden name Anna ?15. Birthplace Russia16. Informant Deceased

Address _____

17. Burial Date thereof 7/11/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Holy RedeemerLocation Baltimore, Maryland18. Funeral director M. L. Creager & SonAddress Thurmont, Maryland

19. 7/2/45 19 _____
 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 19 45 at 7:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 19 45 to July 7 19 45

and that I last saw him alive on July 7 19 45

Immediate cause of death Pulmonary Tuberculosis DURATION 6 Mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. B. Lin M. D. XXXXXX

Address State Sanatorium, Md. Date signed 7/9/45

RECEIVED
JUL 11 1945
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

07010

★ 131
Reg. Dist. No.

1. PLACE OF DEATH;
County Frederick
Frederick-Rural R. D. #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
Mount Pleasant
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
Frederick-Rural R. D. #1
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mount Pleasant
(If rural, give LOCATION)
None
2.(a) If veteran, name war

3.(a) FULL NAME
ELLA MARGARET REESER
3.(b) Social Security Number
None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced W
6.(b) Name of husband or wife William DeM. Reeser
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 13, 1868
8. AGE: Years 76 Months 11 Days 23 If less than one day hrs. min.

9. Birthplace Nr. Middletown-Frederick-Maryland
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER 12. Name Robert Wilson
13. Birthplace Frederick County Maryland
MOTHER 14. Maiden name Mahala Norris
15. Birthplace Frederick County Maryland
16. Informant Donald A. Reeser
Address Frederick, Maryland R.F.D.#1

17. Burial 7/7/45
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Pleasant View Cemetery
Location Nr. Burkittsville, Maryland

18. Funeral director M. R. Etchison and Son
Address Frederick, Maryland

19. 6 July 1945 Elizabeth G. Heck
(Date signed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945 at 7:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....
and that I last saw him dead July 5, 1945 19.....
Immediate cause of death.....
Coronary Thrombosis

Due to Coronary Sclerosis
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings of operations.....
Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE S. P. Schorlman, M.D.
acting deputy medical examiner
Address Frederick Md Date signed 7/6/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUL 9 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: Frederick
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 yrs.
 Hospital, institution, or street address where death occurred:
103 E. 6th Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 103 E. 6th Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME Klavid Fred Roberts Sr. 3. (b) Social Security Number 214-16-0043

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Myra Roberts
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) 2-13-1870
 8. AGE: Years 75 Months 4 Days 22 If less than one day hrs. min.

9. Birthplace West Virginia
 (Town, county, and state)
 10. Usual occupation Laborer

11. Industry or business
 12. Name George W. Roberts
 13. Birthplace West Virginia
 14. Maiden name Hannah Hedde
 15. Birthplace Lewistown - Ind.

16. Informant Mrs. H. F. Roberts Sr.
 Address 103 E. 6th St. - Frederick - Md.

17. Burial Date thereof 7-7-1945
 (Burial, cremation, or removal to another place)
 Cemetery or crematory Mt. Olivet Cemetery
 Location Frederick - Md.

18. Funeral director C. E. Clune & Son
 Address Frederick - Md.

19. 5-July-1945 Elizabeth G. Hack
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945, at 5:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1945, to July 5 1945, and that I last saw him alive on July 3 1945

Immediate cause of death Cerebral Thrombosis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Date signed

RECEIVED BY THE UNITED STATES GOVERNMENT

RECEIVED BY THE UNITED STATES GOVERNMENT

RECEIVED
JUL 6 1945
BUREAU OF

Mr. Shuster

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07012

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

307 Upper College TerraceHow long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 307 Upper College Terrace
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

JACOB ROHRBACK

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Ida Rohrback7. Birth date of deceased (mo., day, yr.) August 23, 18638. AGE: Years 81 Months 10 Days 23 If less than one day hrs. min.9. Birthplace Frederick, Maryland
(Town, county, and state)10. Usual occupation Lawyer11. Industry or business 12. Name Martin N. Rohrback13. Birthplace Sharpsburg, Maryland14. Maiden name Ellen Brunner15. Birthplace Frederick, Maryland16. Informant Mrs. Loretta PoseyAddress Pittsburgh, Pennsylvania17. Burial Date thereof July 18, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olivet CemeteryLocation Frederick, Maryland18. Funeral director C. E. Cline & SonAddress Frederick, Maryland19. 17-July 1945 Elizabeth G. Heck
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 at 1:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to July 16 1945and that I last saw him alive on July 16 1945Immediate cause of death Chronic myocarditis DURATION 14 yearsDue to Due to Other conditions acute dilatation heart 8 days

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Wm M. Smith M.D. M. D. or otherAddress Frederick Md Date signed July 17, 1945

RECEIVED

JUL 19 1915

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Anna Skinner

7. Birth date of deceased (mo., day, yr.)

See 15, 1858

5. (c) If alive, give age..... years

8. AGE:

Years 85Months 7Days 24

If less than one day

9. Birthplace

Frederick County, Maryland

10. Usual occupation

Farmer

11. Industry or business

unemployed

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

Emergency Hosp. Frederick, Md.

burial

Date thereof

July 12, 1945

(Burial, cremation, or removal of body)

Cemetery or crematory

Colored cemetery,

Location

Bartonsville, Md.

18. Funeral director

M. R. Etchison & Son,

Address

Frederick, Md.19. 10 July19 45

(Date read by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 6 Pictus Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 45 at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 2 19 45 to July 9 19 45and that I last saw him on July 9 19 45

Immediate cause of death

Cerebral Hemorrhage

Due to

Cardio Vascular Atrial Fibrillation

Due to

Exhaustion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H. H. Fanning MDAddress Frederick MdDate signed 7-45

RECEIVED
JUL 12 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-a

CERTIFICATE OF DEATH



Reg. Dist. No. 137

1. PLACE OF DEATH County <u>Frederick</u> City or town <u>Libertytown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Frederick</u> City or town <u>Libertytown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>William C. Sappington</u>				3. (b) Social Security Number			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Anna Osella Stately Sappington</u>		6. (c) If alive, give age		2D. DATE OF DEATH <u>July - 27 -</u> 19 <u>45</u> at <u>6 P.</u> M.		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July - 20 -</u> 19 <u>45</u> to <u>July 27</u> 19 <u>45</u> and that I last saw him alive on <u>July - 27</u> 19 <u>45</u>	
7. Birth date of deceased (mo., day, yr.) <u>June 7, 1866</u>		8. AGE: Years <u>79</u> Months <u>1</u> Days <u>20</u> If less than one day <u>hrs.</u> <u>min.</u>		Immediate cause of death <u>Aortic stenosis</u>		DURATION <u>1 yr</u>	
9. Birthplace <u>Libertytown, Md.</u> (Town, county, and state)		10. Usual occupation <u>Retired farmer</u>		Due to <u>Arterio Sclerosis</u>		<u>3 yrs</u>	
11. Industry or business		12. Name <u>Sidney Sappington</u>		Due to			
13. Birthplace <u>Frederick Co. Md.</u>		14. Maiden name <u>Margaret Wagner</u>		Other conditions			
15. Birthplace <u>Frederick Co. Md.</u>		16. Informant <u>St. Gibmore Sappington</u>		Major findings of operations			
Address <u>Libertytown Md.</u>		17. Burial Date thereof <u>July 30, 1945</u> (Burial, cremation, or removal) (month) (day) (year)		Antopsy results		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
Cemetery or crematory <u>St. Peters</u>		Location <u>Libertytown Md.</u>		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of			
18. Funeral director <u>Robert H. Hartley</u>		Address <u>2 Woodsboro Md.</u>		Where did injury occur? (City or town) (County) (State)			
19. July 28, 1945 (Data rec'd by registrar)		Registrar <u>W. C. Sappington</u>		Injured at home, farm, industry, public place (where?)			
				Means of injury		Injured at work?	
				23. SIGNATURE <u>Ofis B. Stone</u>		M. D. or other <u>Libertytown Md.</u>	
				Address		Date signed <u>July - 28</u>	

MASSACHUSETTS STATE DEPARTMENT OF CORRECTIONS

INVESTIGATION OF DEATH

RECEIVED
JUL 31 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07015

Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
135 West All Saint Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 135 West All Saint Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

BASIL SYLVESTER SEWELL, JR.

3. (b) Social Security Number

None

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced M

8. (b) Name of husband or wife Louisa Fry7. Birth date of deceased (mo., day, yr.) March 18, 1881

8. AGE: Years 64 Months 3 Days 28 It less than one day
hrs.min.

9. Birthplace New Market, Frederick-Maryland
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Basil S. Sewell, Sr.13. Birthplace Frederick County Maryland14. Maiden name Harriett Ann Unknown15. Birthplace Frederick County Maryland16. Informant Mrs. Carlos T. ChaseAddress Frederick, Maryland

17. Burial Date thereof 7/19/45
 (Burial, cremation, or removal. When?) (month) (day) (year)
 Cemetery or crematorium Simpson's Chapel Cemetery
 Location New Market, Maryland

18. Funeral director M. R. Etchison and SonAddress Frederick, Maryland

19. 16 July 19 45 Elizabeth G. Hesch
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 19 45, at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7/9 19 45, to 7/16 19 45
 and that I last saw him alive on 7/16 19 45

Immediate cause of death Chronic Coronary Arterial Disease DURATION 4 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE U. G. Baurne Jr. M. D.

Address Frederick, Maryland M. D. or other 7-16-45
 Date signed

RECEIVED

JUL 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07016

Reg. Dist. No.

134

1. PLACE OF DEATH:

County.....Frederick
 City or town.....Rocky Ridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....3 weeks
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Frederick
 City or town.....Rocky Ridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Edward Sharer

3. (b) Social Security Number

705-10-8752

4. Sex.....Male 5. Color or race.....White b.(a) Single, married, widowed, or divorced.....Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....December 4th 1898
 8. AGE: Years.....66 Months.....6 Days.....28 It less than one day..... hrs. min.

9. Birthplace.....Maryland
 (Town, county, and state)
 10. Usual occupation.....Telephone Operator
 11. Industry or business.....

MOTHER 12. Name.....John Sharer
 13. Birthplace.....Maryland
 14. Maiden name.....Ormie (Barriek) Sharer
 15. Birthplace.....Maryland

16. Informant.....Mrs. Cora Valentine
 Address.....Rocky Ridge - MD
 17. Burial (Burial, cremation, or removal. Which?) Date thereof.....July 5 - 1945
 (month) (day) (year)

Cemetery or crematory.....St. John
 Location.....Rocky Ridge - MD
 18. Funeral director.....Willie H. Breeger
 Address.....Thurmont - MD

19. July 3 - 45 (Date rec'd by registrar) 19. 45 M.F. Sharer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....July 2 19. 45 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 15 19. 45 to July 7 19. 45
 and that I last saw him alive on July 7 19. 45

Immediate cause of death.....Tumor of spleen of undetermined origin
 DURATION.....4 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....W.R. Cagle M.D. M. D. or otherAddress.....Summitburg Md Date signed.....7-3-45

RECEIVED
JUL 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:

County Frederick
 City or town State Sanatorium, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 6/25/45
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Since 6/25/45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 613 S. Bond St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Maxine Sherman

3. (b) Social Security Number

214-05-8959

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband

Carl Sherman

7. Birth date of

deceased (mo., day, yr.)

Oct. 22, 1915

6. (c) If alive, give age _____ years

8. AGE:

Years

29

Months

9

Days

0

If less than one day

_____ hrs. _____ min.

9. Birthplace

Aurora, W. Va.

(Town, county, and state)

10. Usual occupation

Waitress

11. Industry or business

FATHER

12. Name

Ernest Sell

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Ethel Dean

15. Birthplace

Ohio

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 22 19 45 at 7:30AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 2519 45to July 2219 45and that I last saw h er alive onJuly 2219 45

Immediate cause of death

Pulmonary Tuberculosis

DURATION

11 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. JohnAddress State Sanatorium, Md. Date signed 7/23/45

RECEIVED
JUL 26 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH



Reg. Dist. No. 131

1. PLACE OF DEATH:
 County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Frederick City Hospital
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Frederick
 City or town Frederick-Rural R. F. D. #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Linganore
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

ANNIE MARIA TOBERY

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M
 6. (b) Name of husband or wife Charles H. Tobery
 6. (c) If alive, give age 76 years
 7. Birth date of deceased (mo., day, yr.) August 12, 1872
 8. AGE: Years 72 Months 11 Days 3 If less than one day
hrs.min.

9. Birthplace Braddock-Frederick-Maryland
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name John Layman
 13. Birthplace Frederick County Maryland

14. Maiden name Catherine Poole
 15. Birthplace Frederick County Maryland

16. Informant Mrs. C. J. Shull
 Address Frederick, Maryland

17. Burial (Burial, cremation, or removal - Which?) July 19-1945
 Date thereof (month) (day) (year)
 Cemetery or crematorium Frederick Memorial Park
 Location Frederick, Maryland

18. Funeral director M. R. Etchison and Son
 Address Frederick, Maryland

19. 17 July 1945 Elizabeth G. Heck
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15th, 1945 at 11:15P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 14 1945, to July 15 1945

and that I last saw her alive on July 15 1945

Immediate cause of death Uremia
Terminal uremic pneumonia

DURATION

5 days

Due to Hypertensive-cardio-vas-
cular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. R. Schoolman, M. D.
 M. D. or other

Address Frederick, Maryland Date signed 7-16-45

RECEIVED
JUL 19 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Walkersville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Irene Wachter4. Sex Female5. Color or race W6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 8, 18808. AGE: Years 65 Months 0 Days 15 If less than one day

hrs. min.

9. Birthplace Frederick Co. Md.

(Town, county, and state)

10. Usual occupation House Keeping

11. Industry or business

12. Name Lycurgus M. Wachter13. Birthplace Fred. Co.14. Maiden name Martha Ellen Longman15. Birthplace Fred. Co.16. Informant Murray S. WachterAddress Walkersville17. Burial Date thereof July 25, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or mt OlivetLocation Frederick18. Funeral director F. C. BartonAddress Walkersville19. 24 July 1945 Elizabeth G. Hark

(Date read by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County FrederickCity or town Walkersville
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945 at 8:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1944 to July 23 1945and that I last saw him alive on July 23 1945Immediate cause of death Carcinoma breast

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel E. Foster Day M. D. or otherAddress Walkersville, Md Date signed July 24, 45

RECEIVED

JUL 25 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

07020

★ Reg. Dist. No. 131

1. PLACE OF DEATH:

County Frederick

City Frederick - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Brunswick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Sarah Waters

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

John Waters

7. Birth date of deceased (mo., day, yr.)

?

8.(c) If alive, give age

— years

8. AGE:

Years

Months

Days

If less than one day

81

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Lee Marshall

13. Birthplace

Maryland

MOTHER

14. Maiden name

Little Mary

15. Birthplace

Maryland

16. Informant

James Eury

Address

Brunswick Md

17.

Brunswick

Date thereof July 15 - 1945

(Burial, cremation, or other disposal)

Cemetery or other place of interment

Park Heights

Location

Brunswick Md

18. Funeral director

C. H. Felt & Son

Address

Brunswick Md.

19.

13 July

1945

Elizabeth K. Heck

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 29 1945 to July 13 1945

and that I last saw him alive on July 12 1945

Immediate cause of death

Cardiac Decompensation
Myocardial Infarction

DURATION

Due to

Cardio Vascular Disease

Due to

Other conditions

Emphysema

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. Lawrence Johnson MD

M.D. or other

Address Frederick Md

Date signed 7-13-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

RECEIVED
JUL 16 1945
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information-carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

Reg. Dist. No.

07021

141

1. PLACE OF DEATH:

County Fredrick
 City or town Brownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 da
 Hospital, institution, or street address where death occurred Schauffen Hospital
 How long in hospital or institution? 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Virginia County London
 City or town Brownsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Alice Ocea Wenner

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Robert Wenner
 7. Birth date of deceased (mo., day, yr.) June 12 1858 8.(c) If alive, give age _____ years
 8. AGE: Years 87 Months — Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Garrison K. Alb
 13. Birthplace Virginia
 14. Maiden name Lidia Vincell
 15. Birthplace Virginia

16. Informant R. R. Wenner

Address London Va.

17. (Burial, cremation, or removal) Which? Buried Date thereof July 4, 1945
 (month) (day) (year)

Cemetery or crematorium Belmont Cemetery

Location Brownsville Va.

18. Funeral director C. H. Felt & Son

Address Brownsville Md.

19. July 1 19 45 Emmie Martin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 45 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 19 45 to July 1 19 45
 and that I last saw him alive on July 1 19 45

Immediate cause of death Exhaustion DURATION ?

Due to Age & heat

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

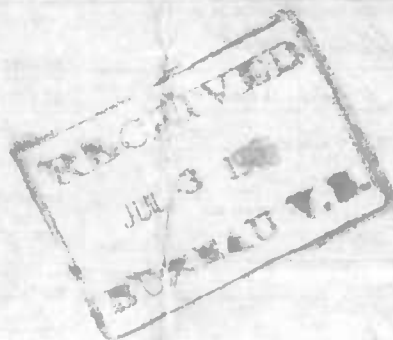
Means of injury _____ Injured at work? _____

23. SIGNATURE William J. Shupaker M. D. or other

Address Brownsville Md. Date signed 7/1/45

HEALTH AND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MEDICAL CERTIFICATION

20. DATE OF DEATH

1945, at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 5

1945

to

July 20 1945

and that I last saw him alive on

July 20

1945

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address

Date signed

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation or removal. Which?)

Cemetery or crematorium

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Registrar

RECEIVED

JUL 23 1945

BUREAU V.S.

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

07023

Reg. Dist. No. 136

1. PLACE OF DEATH: County <u>Frederick</u> City or town <u>Rural - Urbana</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Lifetime</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution? _____				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>md.</u> County <u>Frederick</u> City or town <u>Rural - Urbana</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) <u>none</u> 2. (a) if veteran, name war _____											
3. (a) FULL NAME <u>Isabell Hane Wilcom</u>				3. (b) Social Security Number <u>none</u>											
4. Sex <u>F</u>		5. Color or race <u>W</u>		6. (a) Single, married, widowed, or divorced <u>Widowed</u>											
6. (b) Name of husband or wife <u>Jacob J. Wilcom</u>				6. (c) If alive, give age _____ years											
7. Birth date of deceased (mo., day, yr.) <u>7-17-1864</u>				8. AGE: <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td><u>80</u></td> <td><u>11</u></td> <td><u>13</u></td> <td>hrs. min.</td> </tr> </table>				Years	Months	Days	If less than one day	<u>80</u>	<u>11</u>	<u>13</u>	hrs. min.
Years	Months	Days	If less than one day												
<u>80</u>	<u>11</u>	<u>13</u>	hrs. min.												
9. Birthplace <u>Frederick Co., Md.</u> (Town, county, and state)				10. Usual occupation <u>Housewife</u>											
11. Industry or business <u>Home</u>				12. Name <u>Mrs. Hane</u>											
13. Birthplace <u>Frederick Co., Md.</u>				14. Maiden name <u>Mary E. Beashear</u>											
15. Birthplace <u>Frederick Co., Md.</u>				16. Informant <u>Lawrence R. Wilcom</u> Address <u>near Urbana - Md.</u>											
17. Burial <u>Burial</u> Date thereof <u>7-4-1945</u> (Burial, cremation, or removal, Which?) (month) (day) (year) Cemetery or crematory <u>mt. Olivet Cemetery</u> Location <u>Frederick - Md.</u>				18. Funeral director <u>C. E. Clive + Son</u> Address <u>Frederick - Md.</u>											
19. Date rec'd by registrar <u>7/2</u> 19 <u>45</u> Registrar <u>G. O. H. H. H. H. H.</u>				20. DATE OF DEATH <u>July 1</u> 19 <u>45</u> at <u>5 P.</u> M.											
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>April 30</u> 19 <u>45</u> <u>to</u> <u>July 1</u> 19 <u>45</u> and that I last saw him alive on <u>June 29</u> 19 <u>45</u>															
Immediate cause of death <u>thrombosis</u>				DURATION <u>2 wks</u>											
Due to <u>Chronic Intestinal Neoplasia 5 yrs</u>				Due to _____											
Other conditions _____				Other conditions _____											
(Include pregnancy within 3 months of death)															
Major findings of operations _____ Date of op. _____															
Autopsy results _____															
PHYSICIAN: Please underline the cause to which death should be charged statistically.															
22. VIOLENCE: If death was due to external causes, fill in the following:															
Accident, suicide, or homicide _____ Date of _____															
Where did injury occur? _____ (City or town) _____ (County) _____ (State)															
Injured at home, farm, industry, public place (where?) _____															
Means of injury _____ Injured at work? _____															
23. SIGNATURE <u>Ernest P. Roof, Md.</u> M. D. or other _____ <u>New Market, Md.</u> Date signed <u>July 2, 1945</u>															

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUL 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

County FrederickCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred Emergency HospitalHow long in hospital or institution? 2 days

3. (a) FULL NAME

4. Sex male5. Color of skin white6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife Annie E. Zimmerman7. Birth date of deceased (mo., day, yr.) November 27, 18778. AGE: Years 67 Months 8 Days 3 If less than one day hrs min.9. Birthplace Frederick County, Maryland
(Town, County, and State)10. Usual occupation Farmer

11. Industry or business

12. Name John M. Zimmerman13. Birthplace Frederick County, Maryland14. Maiden name Elizabeth Galunberg15. Birthplace Unknown16. Informant Joseph B. ZimmermanAddress Baltimore, Md.17. (Burial, cremation, or removal, Which?) Burial Date thereof Aug. 21, 1945
(month) (day) (year)Cemetery or crematory St. John's CemeteryLocation Frederick, Md.18. Funeral director Admiral Co.Address Middletown, Md.19. 2 Aug 1945 Elizabeth G. Heck.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. 511 East Church
(If rural, give LOCATION)2. (a) If veteran, name war NO

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 30, 1945 at H.P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23, 1945 to July 31, 1945and that I last saw him alive on July 30, 1945Immediate cause of death Cerebral HemorrhageDue to Cardio Vascular Cerebrallesion

Due to

Other conditions Exhaustion

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Lawrence Fading MDAddress Frederick Md Date signed 7-31-45

RECEIVED

AUG 4 1945

BUREAU V.R.